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Rights and Efficiency in American Health Law

By M. Gregg Bloche

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During the 1960s and 1970s, the individual rights revolution that swept through American society remade much of the nation's health law in its image. Sick people acquired the right to be told of the risks and benefits of proposed treatments and then to give thumbs-up or thumbs-down to their doctors' decisions. Successful suits for medical negligence went from rare to commonplace. Elderly and poor Americans achieved statutory rights of access to publicly funded health care, and courts burnished these rights with myriad procedural protections. The critically ill and their families won the right to refuse aggressive, life-sustaining treatments. Psychiatric patients acquired new veto power over hospital confinement and drug therapy, and biomedical research subjects gained myriad safeguards grounded in the principle of informed consent.

By the early 1980s, the law governing American medicine embodied, in form if not in practice, the ideal of the individual as author of his or her own clinical fate. This ideal portrayed patients as sovereign clinical consumers, entitled to make decisions about their care without regard for the financial consequences borne by others. So long as the assorted others—mainly employer-sponsored health insurance plans and taxpayer-supported federal and state programs—

paid more or less uncomplainingly, this ideal seemed immune to challenge. It appealed, diversely, to liberal proponents of the individual rights revolution and to conservatives inclined toward pursuit of efficiency through deference to consumer choice. It disregarded the fact that consumers of healthcare often do not pay for what they choose.

Today, the paradigm of personal choice in medical matters is under assault from several directions. Pressed by taxpayers and cost-sensitive employers, public and private healthcare payers no longer finance individual choice uncomplainingly. Medicare, Medicaid, and employer-sponsored health plans pursue management strategies designed to discourage high-cost consumer choices. Subscribers to HMOs and other managed care plans face an array of financial incentives, bureaucratic barriers, and contractual limitations that constrain access to treatment options, alternative providers, and information about risks and benefits. Federal preemption of state tort and contract law applicable to employer-provided health benefits shields many of these constraints against legal challenge. Tort reform proposals pending in a number of states would reduce the scope of healthcare providers' potential liability for failure to obtain informed consent, and proposed changes in state mental health law would diminish the ability of patients with impaired judgment to refuse hospital confinement and treatment.

More surprisingly, perhaps, skepticism about the primacy of individual rights in the medical sphere has grown among

advocates for the health of the disadvantaged. In response to mounting epidemiological evidence that personal health is more closely tied to social status, income level, race, education, and environmental exposure than to per capita medical spending, some advocates for the disadvantaged have questioned the wisdom of public spending on healthcare programs that aspire to emulate the individual choice enjoyed by well-insured, fee-for-service patients. Balanced against the benefits of spending on education, economic development, and other health-promoting public programs, the benefits of achieving 1970s ideals of personal choice in medical programs for the poor seem, to them, worth forgoing. Tightly-managed HMOs and other prepaid plans, some suggest, may achieve more on the health promotion front (e.g., through systematic mammography and blood pressure screening, physical fitness, and health education programs) than classic fee-for-service coverage, while providing almost the same therapeutic benefits, at lower cost. Beneficiaries lose a measure of personal freedom when they become ill, but this loss is more than made up by directing the savings to more cost-effective social programs.

This line of thinking is also gaining support abroad. Advocates of an international human right to health increasingly stress the socioeconomic determinants of health, including education, income, social peace, and respect for civil and political rights. India, South Africa, and other "third world" democracies are experimenting with the HMO model as a means of making comprehensive, basic medical care available to

the poor at a feasible cost. Sacrificing a measure of personal choice to universalize access to basic health services has much appeal, as a matter of equity, in impoverished societies where rudimentary medical care is unavailable to millions.

These misgivings about the priority of personal choice in health policy fit awkwardly with the priority of patient autonomy in American health law and in the growing body of international ethical and legal norms bearing upon personal rights in the medical setting. Put simply, American law, international codes of medical ethics, and such legal sources as the Nuremberg Tribunal, European and other regional human rights commissions, and the United Nations reflect the principle that sick patients should be told the risks and benefits of clinical alternatives and then be allowed to make their own choices from among them. To the extent that managed health plans and assorted efficiency-oriented

trade-off strategies, relying instead on opaque promises to cover "medically necessary" care. To their credit, health plans have become more lucid in their descriptions of preauthorization requirements, in-network/out-of-network coverage differentials, and the like. But they usually disclose little about their clinical decision protocols, financial incentives to providers to limit care, and other management practices that shape sick subscribers' options.

Moreover, most employers offer only one or a few subsidized group plans, leaving employees with the "choice" between these and the often prohibitive cost of purchasing unsubsidized individual insurance. Employers that do not offer health benefits leave their workers with only the latter option. Likewise, public programs for the poor, principally Medicaid in the United States, typically offer few, if any, options when they channel beneficiaries to managed care plans. "Third world" experiments with HMOs

employers to offer diverse menus of health plans is unlikely, but tax and other incentives for voluntary expansion of employees' health plan options are a possibility, and health coverage purchasing cooperatives could extend such choice to small businesses and independent subscribers. Political support for broadening the coverage options available to Medicaid managed care subscribers is problematic, but advocates for the disadvantaged might do better to focus on this objective (and on the need for sufficient subsidies to "mainstream" Medicaid beneficiaries into plans with many working class subscribers) than to oppose managed care for the poor outright.

Yet, such developments can at best reduce, not eliminate, the tension between the 1960s and 1970s ideals of individual autonomy embodied in American health law and 1990s thinking about efficient allocation of resources to maximize the health of populations. The paradigm of informed consent to medical intervention that lies at the core of American health law privileges a sick patient's preferences at the moment of medical decision over his or her economizing preferences at the time of health plan enrollment—and over achieving the biggest "bang for the buck" when devoting social resources to health.

From a population-oriented perspective, this is plainly inefficient. Indeed, growing evidence suggests that much of our response to individual medical need is inefficient, in aggregate health terms, when compared to equivalent spending on education and job training, environmental protection, and other health-related social needs. Yet, we are hardly ready, as a society, to ignore individual clinical need, or to give up our empathy and ethical regard for the fears, distress, and hopes of the sick when medical decisions loom. To the contrary, most of us would not want to live in a society that required us always to disregard our private worries and emotional ties in deference to the greatest good for the greatest number. In the years ahead, American health law will need to mediate this central tension, between our intimate and public selves, between compassion and calculation, and between rights and efficiency.

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Much of our response to individual medical need is inefficient.

health promotion programs pursue savings by foreclosing alternatives (and/or by denying patients information about them), such programs challenge governing ideals of patient autonomy.

Proponents of the managed care revolution in the United States have sought to finesse this dilemma by construing the act of *subscribing* to a managed health plan as *anticipatory* consent-giving (before the onset of medical need) to the plan's bundle of choice-reducing policies. This strategy seeks to rescue the paradigm of *personal autonomy* by relocating disclosure and consent from the bedside to the employee benefits office, or wherever else people sign up for health plans. Its proponents contend that this approach respects autonomy by allowing consumers to bring their diverse personal preferences to bear on choices between health plans with different economizing policies.

This assumes that *competing* health plans explain their distinctive cost-benefit trade-off policies (and constraints on patient choice) to consumers and that consumers have access to a diverse range of plans. The reality of today's medical marketplace falls far short in this regard. In their promotional campaigns and contracts with subscribers, health plans typically reveal little about their cost-benefit

for the poor, in India and elsewhere, have tended to suffer from the same defect.

Some of managed care's more exuberant defenders dismiss these concerns, claiming that plan disclosures about their cost-benefit trade-off policies are adequate, that employers offering only one or a few subsidized plans act as employee purchasing agents (and thereby give surrogate consent) when selecting from among many alternatives, and that constraints on choice in Medicaid and other public programs are legitimated by *collective, political consent*. Others favorably inclined toward the managed care model take these concerns seriously but insist that markets can adequately address them. They urge health plan managers to reveal more about their cost-benefit trade-off policies, and they advise employee benefits managers and administrators of government programs to insist on such disclosure and to offer wider menus of alternative plans.

Government action holds out the potential to spur such change. Courts and regulators could tie the acceptability of limits on clinical alternatives more closely to the clarity and specificity of health plan disclosures to subscribers about their cost-benefit trade-off policies. In the current political environment, federal intervention to require